QUARTERLY REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE

On

State Plan 2002: Blueprint for Change

Session Law 2001-437

July 31, 2002

This second quarterly report is submitted to the Legislative Oversight Committee (LOC) on Mental Health, Developmental Disabilities and Substance Abuse Services, pursuant to the requirements of Session Law 2001-437. As in the March 31, 2002 report, major developments in implementation of system reform are presented first with the specific report items contained in the statute immediately following.

State Plan Revision

The first annual revision of the State Plan was released on July 1, 2002. *State Plan 2002: Blueprint for Change* contains both new material and expansion of the original concepts. There is a discussion of key policy developments over recent decades that have set the direction and established the framework for all state systems that serve people with disabilities. There is also an overview of advances in the field over the last 20 years that are making it possible for people to live meaningful and satisfying lives in natural communities of their choice. The revision expands the descriptions of major reform concepts, providing additional detail and clarifying issues that have been confusing. Substantial progress toward implementation of local service systems is reported in chapter two. A discussion of financing strategies is included in chapter 5.

With this first revision the focus moves from a relatively straightforward presentation of reform concepts toward the more technical aspects of actual implementation. The State Business Plan and Timeframe sections have been expanded and revised into one technical document; the State Strategic Business Plan. The format and content of the State Strategic Business Plan closely parallels that of the Local Business Plan. The Local Business Plan section has been substantially revised to clarify the requirements including a weighted scoring system that the State will use to certify local plans, and forms and checklists to be completed for submittal of local plans.

Division Reorganization: A new technical document in the revision is an overview and brief discussion of the Division reorganization plan. The reorganization implementation will be transitional with full implementation by Jan 1, 2003 The new structure dissolves the disability sections into a functional cross-disability configuration clustered around five major spheres of operation. This design is supported by S1005 (Section 21.64 ((a-c)), pages 124-5), and various study reports. These areas are: state-operated services, community policy, program development and system implementation, regulation and finance, customer relations and advocacy, and administrative support services. Section chief's for four of the five areas were announced on July 1, 2002. They are, Dr. Stan Slawinski for state operated services, Flo Stein for community

policy, program support and system implementation, Phillip Hoffman for regulation and finance, and Don Willis for administrative support. A position description for the remaining position for customer relations and advocacy has been developed preparatory to recruitment. These five section chiefs, the director and the deputy director will comprise the executive leadership team. Each section includes team leaders who will manage the various functions and activities overseen by the Section Chief. Division staff are preparing lists of current tasks and functions so that as operational details of the new organizational structure are developed appropriate integration of current required activities will take place over the coming months. The transition to full implementation will occur between October, 2002 and January 2003.

One of the primary goals of the reorganization is to place system reform at the central core of Division activities, from which all else proceeds. As such, the current implementation committees and workgroups may change as system reform is fully internalized into the new organization. Additionally, the content and timeframes in the State Strategic Business Plan may need to be further revised to reflect changes brought about by the reorganization or necessitated by budget cuts. In that case a supplemental mid-year revision of the State Strategic Business Plan will be issued.

Just as the area programs are challenged to transform themselves into public agencies that manage rather than provide direct services, the reorganization of the Division will require its staff to assume broader leadership skills and adopt different methods of evaluating system effectiveness. As the focus of local systems moves toward fixed financing for LME's and direct services provided by a network of qualified providers, administrative processes and data gathering requirements will need to be streamlined to place the emphasis on measuring outcomes rather than prescribing and monitoring each step in a process.

Local Systems Development

Counties are expected to select their model of governance and submit Letters of Intent to the DHHS Secretary by October 1, 2002. As of July 22, 2002, forty-eight counties have submitted Letters of Intent.

Phase-In of Local Service Systems: The Reform Statute and State Plan require Counties/LME's to submit preliminary versions of their Local Business Plans by January, 2003 and the completed version by April 1, 2003. In response to concerns raised by the North Carolina Council for Community Programs about the time lines for submission of the Plans, a meeting of the LOC Chairs, the Council and the Division Director resulted in the adoption of a 3 tiered phase-in schedule for implementation spread over three years. Local Business Plans continue to be due by the April 1, 2003 date, but certification of the local plans will be based on the local preference for a Phase I, II, or III certification date. Phase I systems will be scheduled for certification as of July 2003, with Phases II and III following in the next two years. The details of the Phase-In schedule and the corresponding requirements for the Local Business Plans are contained in a June 17th, 2002 letter to the LOC Chairs. A copy of the letter is attached to this report.

As of July 22, 2002, the Area Programs shown in the table below, representing up to 61 counties have opted for a Phase I certification/implementation date of July 1, 2003. The Area Directors of the Phase I Group are meeting monthly with the Division Director, Deputy and staff to work out the details of transition and consider various pilot/demonstration proposals. Division technical

assistance staff have been assigned to each Area Program in the Phase I group. Minutes of these meetings are available on the Department web site.

Area Program	Counties	Consolidation
CenterPoint Human Services	Davie, Forsyth and Stokes	
Pathways Mental Health, Developmental Disabilities & Substance Abuse	Gaston, Lincoln and Cleveland	
Mecklenburg	Mecklenburg	
Albemarle Mental Health Center & Developmental Disabilities & Substance Abuse Services Roanoke Chowan Human Services Center	Camden, Chowan, Currituck, Dare, and Pasquotank Bertie, Gates, Hertford and Northampton	Pending
Piedmont Mental Health, Developmental Disabilities & Substance Abuse Services	Cabarrus, Rowan, Stanly and Union	
VGFW Area Authority	Vance, Granville, Franklin and Warren	
Duplin-Sampson Mental Health, Developmental Disabilities & Substance Abuse Services Lenoir County Mental Health, Developmental Disabilities & Substance Abuse Center Wayne County Mental Health	Duplin and Sampson Lenoir Wayne County	Pending
Smoky Mountain Center for Mental Health, Developmental Disabilities & Substance Abuse Services	Cherokee, Clay, Graham, Haywood, Jackson, Macon and Swain	
Blue Ridge Center for Mental Health, Developmental Disabilities & Substance Abuse Services Trend Area Mental Health, Developmental Disabilities & Substance Abuse Authority Rutherford-Polk Area Mental Health Developmental Disabilities & Substance Abuse Authority	Buncombe, Madison, Mitchell and Yancey Henderson and Transylvania Rutherford and Polk Counties	Pending
Edgecombe-Nash Mental Health, Developmental Disabilities & Substance Abuse Services Halifax Wilson-Greene Area Mental Health, Mental Retardation, & Substance Abuse Services	Edgecombe and Nash Counties Halifax Wilson and Greene	Pending
O-P-C Mental Health Developmental Disabilities & Substance Abuse Authority	Orange, Person and Chatham	
Wake County Human Services	Wake	
New River Behavioral HealthCare	Alleghany, Ashe, Avery, Wilkes and Watauga	
Neuse Center Mental Health, Mental Retardation, & Substance Abuse Services	Carteret, Craven, Jones and Pamlico	

Technical Assistance

The Division continues to make presentations on the State Plan at conferences and meetings around the State as needed. However, over the past eight months most people have heard about the basic concepts in the Plan and the emphasis moves now toward the more technical aspects of implementation. Division leadership is meeting regularly with the LME's who are part of the

first phase-in group to map out details and evaluate potential demonstration sites for various components of reform.

The Division Director, Deputy and Division staff have provided technical assistance and attended public forums and board meetings with the following:

Centerpoint; Edgecombe Nash; Albemarle, Roanoke.- Chowan; Catawba, Blue Ridge/Trend/ Rutherford, Polk; Smoky Mtn, Piedmont, VGFW, Mecklenberg, Wake; and Duplin-Sampson, Lee-Harnett, Mecklenburg, Cumberland, Catawba, Crossroads, Pathways, and Neuse. In addition, meetings have occurred with the Psychological Association, Psychiatric Association, Provider Council, and consumers and families. Presentations were also given for DSS Attorneys, Primary Health Care Association, the Client Rights Conference, the DSS Conference in Atlantic Beach, NC Families United, and others.

The Division is also assembling a group of staff to act as ongoing liaisons and technical assistants to counties and area programs in Phase I. Expectations for these staff include:

- Providing on and off site policy guidance consultation to the Phase I LME's
- Oversee the development of the Local Business Plan
- Problem solve with all staff assigned to each of the Phase I LME's
- Share the knowledge gained with other members of the Division.

Technical assistants will receive ongoing support and supervision from Division leadership.

Additionally, the National Alliance for the Mentally Ill in North Carolina (NAMI) has prepared two excellent technical assistance documents on system reform aimed toward individuals with disabilities and their families. Technical Assistance Bulletin #1 centered on "best practices" services for persons with severe mental illness. Technical Assistance Bulletin #2 is on Consumer and Family Participation in Quality Management. These bulletins do a remarkably good job at explaining complicated topics. These documents are posted on the NAMI website at www.naminc.org.

Services and Programs

Progress toward reform is occurring on a number of fronts simultaneously The changing system must also continue to provide needed services to people without interruption during the change process and support them through the transition periods. First steps toward the community-based system called for in the State Plan and reducing system reliance on institution and facility-centered care are occurring. Briefly, the progress points are:

ASAM Service Continuum: The Substance Abuse Services Workgroup has categorized all of the 24-hour/residential services (e.g. supervised living, detox residential treatment, etc) statewide by county, region and ASAM levels that reflect best practice. The group is in the process of entering all specialty periodic substance abuse programs such as MAJORS, Perinatal and others to this database. The information will be provided to the area programs/LME's so that they can identify services available and address gaps in their ASAM service continuum. This task should be completed by September 15, 2002.

Prevention Services Reflecting Best Practice: The State Incentive Grant staff continues to work with CSAP and PIRE (the evaluation team) to identify a menu of selective and indicated prevention services to be provided to area programs/LME's for statewide implementation. A licensure rule for Prevention Services relative to the State Plan is in draft form and is currently being reviewed by staff. The Qualified Substance Abuse Prevention Specialist definition and staff competencies have been completed and presented to the Commission Rules Committee in July 2002. Negotiations with the Division of Medical Assistance cannot occur until the menu of substance abuse prevention services has been selected. The goal of rolling out a reimbursable substance abuse prevention benefit for 1500 children and their families is dependent on the negotiations and funding from DMA.

Community Service Expansion: Four regional Adult Mental Health Coordinators Workgroups have submitted plans from all but two Area Programs to the Division. These plans focus on: the analysis and expansion of community services that will be needed to facilitate discharge of persons and reduction of beds at the state psychiatric hospitals; reduce admissions at the state hospitals subsequent to Olmstead assessments; and reporting and tracking services and the people who have moved into community.

Much of the current work on building community capacity is occurring in connection with the Olmstead Plan initiative. Individuals who have been hospitalized longer than 60 days have received Olmstead Assessments and personal preference interviews. Further information on specialty service and support needs are being gathered from hospital social work and treatment staff and area program personnel. Area program, hospital, and division staff are working on improved guidelines to ensure that there is a high degree of collaboration between the state and local service systems on discharge planning. Similar planning is proceeding to assure transition and treatment needs are adequately met for hospitalized children and youth.

Prior to the interview process that was initiated in accordance with the State's Olmstead plan, 135 individuals currently residing in the Mental Retardation Centers were identified as meeting Olmstead criteria for community re-entry. Planning for the transition of these individuals to community living arrangements was initiated. Plans, developed during each individual's annual planning process, include assessments of supports needed and the corresponding projected budgets. As of May 31, 2002, 74 plans had been completed with 61 remaining in progress.

Since the onset of the DHHS Olmstead initiative, a total of 1626 interviews with residents of the Mental Retardation Centers have been completed. These interviews are part of an assessment protocol to identify those interested in leaving the institutions and the information is discussed at each person's annual planning meeting.

Enhanced Behavioral Care in Nursing Facilities: The Adult Mental Health Section is working with the Division of Medical Assistance to develop an enhanced behavioral health level of care in designated community nursing facilities. This initiative is planned to serve some individuals who are currently residing on the certified nursing units at Cherry Hospital. An informational meeting for those nursing facility operators who have expressed interest in the project is scheduled for July 30th to discuss expectations including:

- Eligibility Criteria for Enhanced Behavioral Care – types of residents to be served,
- Staffing and Training Issues;
- Transfer of State Hospital certified nursing facility beds – CON requirements;
- Licensure and Certification;
- Preliminary Cost Estimates.

Downsizing Activities: By the end of Fiscal Year 2001-2002, the mission of the state psychiatric hospitals will have begun to narrow, consistent with the State Plan. The certified nursing facility service units at Broughton and John Umstead hospitals have been eliminated and the one at Cherry Hospital reduced. The individuals cared for in these units have been transferred to community nursing facilities where the necessary capacity was already in place or to the North Carolina Special Care Center at Wilson.

The Wright Building at Dorothea Dix Hospital was closed on July 1, 2002 with all but five individuals served by the program relocated to community. The five individuals who were found not ready for community placement have been moved to other units within the hospital. The Division is closely following those discharged to assure satisfactory community placement and supports. The Skilled Nursing ward at Cherry Hospital, and the nursing level wards at both John Umstead and Broughton Hospitals were closed as of July 1, 2002 with the residents transferred to community nursing facilities, other state hospital wards or the Special Care Facility at Wilson.

Consolidated Hospital Proposal: The physical condition of the four state psychiatric hospitals is a constantly increasing drain on scarce system resources. Some of the hospitals date from the mid-nineteenth century during the rise of the asylum era. Others were pressed into use as hospitals, but built for a different purpose. All of them have been cobbled together at different times over the years in response to different needs; none of them are designed for efficient staffing; all of them are aging and in need of replacement or major renovation.

As part of the plan to reduce the total number of state psychiatric beds, and find a long term solution to the staggering costs of maintaining the old facilities, a plan has been brought forward to consolidate two of the four hospitals and build a single new physical facility in their place. John Umstead Hospital, serving 14 counties and seven Area Programs in the North Central Region, and Dorothea Dix Hospital, serving 16 counties and eight Area Programs in the South Central Region have been proposed. The new state-of-the-art hospital would serve a combined Central Region, consisting of 26 counties and 13 current Area Programs with a combined population of 3,232,098 as of July 2001. In this plan, two Area Programs are proposed to realign with the East Region to more evenly balance catchment areas. Several possible sites in the proposed new Central Region are under consideration for the new facility, whose design would closely resemble the schematic design previously developed for a new Dorothea Dix Hospital.

Renovation and Expansion of ADATCs: Plans are underway to expand the capacity of the Alcohol and Drug Treatment Centers to provide acute crisis/detoxification services, thereby diverting substance abuse admissions to the state psychiatric hospitals. These plans include design, development and renovations at Julian F. Keith ADATC, Black Mountain, an 80-bed residential treatment facility serving residents of western North Carolina; Walter B. Jones

ADATC, Greenville, a 76-bed, short-term residential treatment center serving 33 counties in the Eastern Region and five counties in the South Central Region, and Butner ADATC**,** at Butner, a 60-bed acute and rehabilitation center serving 16 counties of the North Central Region and 10 counties of the South Central Region. Proposed architectural designs have been received and renovations are underway.

Expansion of Nursing Beds: Plans are underway to expand the intermediate and skilled nursing level beds in the Western Region. Black Mountain Center, Black Mountain, currently serves 73 residents. Expansion will provide increased bed capacity and a broadened mission that more closely coincides with that of the North Carolina Special Care Center at Wilson.

Closure of Whitaker School: Whitaker School is a residential treatment center located on the grounds of John Umstead Hospital, for 38 youth, ages 12-17. The condition of the present facility is such that the program cannot continue to operate in the present location. Additionally, there is a need to expand the proven success of the program's Re-Education Model to other areas within the State. Using a Request for Applications process with funding from the Mental Health Trust Funds, two new centers are being developed, each to serve 18 adolescent boys and girls. The new units will be functioning by December, 2002, with full closure of the current Whitaker School facility by July 1, 2003. Responses to RFA's have been received and are currently under review.

Child Mental Health System of Care: System of Care is a Best Practice model that is being implemented in North Carolina. The original first year goal of System of Care roll out in 30 counties has nearly doubled to 56 counties. The System of Care Benchmark Assessment Grid was completed by all 100 counties in North Carolina. The assessment focused on three primary areas: community collaborative development, person-centered planning through Child and Family Teams, and genuine family involvement (no *token* families). Along with the 22 Federal System of Care demonstration counties, 34 additional counties *for a total of **56** counties* met year one standards for System of Care readiness. All 56 counties have completed or are in the process of completing **at least 93% of all identified benchmarks** of System of Care implementation. This is a very substantial accomplishment made possible through the energy and dedication of many people – professionals, advocates, families, at both local and state levels. System of Care in North Carolina is well on its way toward the ultimate goal of helping families help their children stay healthy, at home, in school (or work) and out of trouble.

Projects Held, Pending Funding

Two projects were planned for early implementation but loss of substantial funding from the Mental Health Trust Fund has put them on indefinite hold:

Substance Abuse Crisis Triage Unit(s): The establishment of a 24-bed substance abuse crisis triage unit with complimentary intensive outpatient program for Wake County is pending based on any new Mental Health Trust Funds identified for the activity. Similarly, plans for the development of 15 additional community-based substance abuse crisis triage units with intensive outpatient treatment programs for other parts of the State have been put on hold pending additional Mental Health Trust Funds.

Substance Abuse Services for Children and Adolescents: The goal of expanding local community child and adolescent substance abuse services by 35% has been delayed due to the loss of Mental Health Trust Funds in the current budget crisis. The activity cannot move forward until funding becomes available.

Administrative and Infrastructure Issues

Progress is also underway in developing the processes and structures intended to support the new system.

Uniform Portal/Core Functions: This Workgroup has developed an outline and flow charts of the major components of the Uniform Portal System and Crisis Line. Core Functions as pathways to system access are also being developed by this group. The actual content of the screening and assessment instruments is being developed by the Best Practices Workgroup. The project due date in the State Strategic Business Plan for standardized access criteria is October 1, 2002, with standardized protocols for screening, referrals and assessments to follow by April 1, 2003. (Page 29). The entry relating to core functions on page 25 is an erroneous duplicate with a date of July 1, 2002.

Competent Workforce: The original Competencies workgroup continues to work on establishing a competency-based system for qualifying workers at all levels of the system. A revision of the original competencies document was included in the July 1, 2002 Blueprint for Change. Since that submission Division staff presented the first component of the competencies framework to the Rules Committee of the Mental Health Commission. The Committee supported the language defining Qualified Professional leading to submission to the full Commission in August. The workgroup is continuing to work on supervisory competencies at all levels, paraprofessional, associate professional and qualified professional.

State Level Staff Development Plan: The Division's reorganization plan outlines competencies required by state level staff. The skill sets and knowledge base necessary for those working at all levels of the new system are changing and an investment in re-tooling must take place. To this end, the Division has applied for a small grant from the federal Department of Health and Human Services, Office of Planning to develop a staff development initiative for Division members. Meanwhile, staff training is already underway. Three half-day staff conferences on the Division reorganization and the vision, mission, values and ethics of public service were held July 31 and August 6th. Additionally, staff are developing extensive lists of functions and tasks that they currently carry out in order to assure that all required activities are included as the details of the reorganization are fleshed out. Staff Development personnel will draft a formal development plan derived from and based on the actual requirements of the reformed Division and an assessment of training needs.

Expansion of Directly Enrolled Providers: An implementation workgroup has studied the issue of directly enrolling network providers in lieu of the current system of having contracted private providers bill under the area program medicaid billing number. The group has made a preliminary recommendation for expansion pending evaluation of collateral issues including cost, reimbursement system for both medicaid and wholly state funded services and impact on other divisions within the department. The report is currently awaiting a fiscal statement. A final recommendation will be submitted to the division director by August 30th.

Consolidation of DHHS Advocacy/Ombudsman Services: A workgroup composed of consumers and families completed an initial report on the impact and relative value of consolidation of current DHHS programs which was submitted to the LOC in April, 2002. A second interim report with recommendations to the Secretary has been completed and delivered to the LOC. Should the Secretary accept the workgroup's recommendation to undertake further study of Division and DHHS consumer advocacy programs, a final report will be completed by October 1, 2002.

Cost Modeling: The study to determine the reasonable costs of operating an LME is nearing completion. Working with a group of area program directors, the consultant developed a template of the functions identified as activities of the LME and forecasted likely volumes of task/service across a variety of regions. Preliminary information was shared with division leadership in mid-July with completion of the project expected by mid-August, 2002. During the visit in July, the cost modeling consultant also met with members of the Providers Council to discuss various aspects of the LME cost modeling. Cost modeling of the service benefit packages has begun with completion planned on or about October 30, 2002.

Waiver Re-Design: Home and Community Based Services Medicaid Waivers are a significant source of funding developmental disabilities services. The Division began the process of re-designing the State's Waiver (CAP/MR-DD) in January, 2002 and submitted draft proposals to the Division of Medical Assistance on July 1, 2002. Additional changes were agreed upon by both divisions which require additional waiver rewrites. This process included the establishment of two broad stakeholder groups, a CAP Waiver Advisory Committee, and a separate advisory committee to support the development of a new Waiver specifically for survivors of traumatic brain injury. In addition, Division staff held four public forums to discuss changes under consideration in the existing Waiver and to answer questions about the re-design and receive suggestions and comments.

The major changes proposed in the initial draft include:

- Submission of a technical amendment to the current Waiver to institute some cost constraints necessary to insure that the Waiver remains within the established budget,
- Creation of a Supports Waiver to provide supports to those living in their own home or their family home and need a minimum amount of specialized services,
- Creation of a new Comprehensive Waiver to provide more flexible service options,
- Completed Waiver for survivors of traumatic brain injury,
- Planned closing of the existing CAP/MR-DD Waiver after a 6 month transition to the new Waivers.

Since the submission, Directors and staff of both the Divisions of Mental Health and Medical Assistance have entered into negotiations intended to insure that all elements of the re-design are consistent with the current state-of-the-art in utilization and management of Waivers for this population. The Technical Amendment to the current CAP-MR/DD Waiver has been reviewed and minor changes agreed upon. DMA has agreed to "fast track" the document through their process for submission to CMS by September. DMH and DMA have recently resolved issues surrounding the TBI Waiver regarding the cost of level of care (ICF vs SNF) to be used to

calculate cost neutrality for this waiver. The Department is preparing a request to the Appropriations Committee requesting to move certain funds to a specific waiver account to be used as match dollars. If approved, the TBI Waiver should also be ready for submission to CMS in September. The new Comprehensive and Supports Waivers are being rewritten to better reflect the financial policy and service delivery strategies in the State Plan. The revised timeline for CMS submission of these two waivers is January 2, 2003.

Integration of Blueprint for Change, DHHS Long –Term Care and Olmstead Plans: This has been delayed pending finalization of the Olmstead Plan.

Integrated Payment and Reporting System (IPRS): IPRS replaces the outdated Pioneer billing and information system and is designed to solve many technical problems of information and data collection and management. Target population changes contained in the State Plan Revision are currently being programmed into the IPRS system for eligibility determination purposes. Over the next year, the treatment, services and supports comprising the benefit packages for people served by the reformed system will be finalized and added for implementation on July 1, 2003. IPRS has been piloted in two Area Programs and is scheduled to begin statewide roll-out on July 1st, 2002. The statewide implementation schedule is presented in the table below:

Phase 1	Phase 2	Phase 3	Phase 4
Wayne	Sandhills	Crossroads	Edgecombe-Nash
Guilford	Tideland	Cumberland	Pitt
Mecklenburg	Alamance-Caswell	Onslow	Riverstone
Neuse	Albemarle	Blue Ridge	Rockingham
New River	Durham	Catawba	Trend
Pathways	Lee-Harnett	Centerpoint	Foothills
Smoky Mountain	OPC	Davidson	
VGFW	Roanoke-Chowan	Piedmont	
	Southeastern Regional	Randolph	
	Wake		
	Wilson-green		
	Rutherford-Polk		

Session Law 2001-437, Section 3 Reporting Requirements

Pursuant to the requirements in Section 3,(a), the status of items listed in Section 3,(a), 1-9 are:

Section 3(a), (1) State Plan: The original plan was submitted to the LOC on December 1, 2001 as required. The first annual revision of the Plan was released on July 1, 2002. This item will be dropped from further reports.

Section 3(a), (2) Rules Review: This was submitted with the original State Plan submission in Rules Report Addendum and will be dropped from future reports. The Division continues to participate with the Rule Coordination provision among the divisions and programs of the Department.

Section 3(a), (3) Oversight and Monitoring Functions: State oversight and monitoring of local service systems is a joint effort with the Division of Facility Services with regard to licensure requirements. Provider monitoring protocols to be used by LME's are being developed as part of a statewide, integrated quality management structure which is intended to focus primarily on system and individual outcomes rather than extensive process measures. A monitoring workgroup developed a draft report delineating protocols for monitoring under a State Plan system. Guidelines for monitoring presented in this report to the Quality Management team of the Quality of Care Committee include:

- Stewardship of State resources must be considered,
- System must be consistent,
- Not duplicative,
- Have meaningful family/consumer involvement,
- Be outcome-oriented,
- Participant driven and person centered data collection,
- State responsible for establishing monitoring standards and benchmarks,
- All MH/DD/SA services provided to individuals should be licensed,
- LME monitoring must be used for quality improvement purposes,
- Consistency of monitoring should be verified through inter-rater reliability measures,

Section 3(a), (4) Service Standards, Outcomes, and Financing Formula: Service standards and clinical protocols are in development. The Clinical Protocols for Medication Management of specific diagnostic categories have been updated. Person-centered planning, self-determination, rehabilitation and recovery are philosophies adopted in the State Plan. Training is being provided on person-centered planning and self-determination. Service standards are also found throughout the Plan and requirements for LME's. Examples include the requirement that access to intake and assessment services must be no farther than 30 minutes or 30 miles and crisis/emergency services must be available 24/7. Work continues on developing outcome measures that will be used to complete an annual, system-wide report card. As noted above outcome data will largely replace the extensive system of process measures that so complicate the current system. The bottom line in measuring success is how effectively the system meets its goals of helping people live in natural communities with the healthcare/treatment/services needed, stable housing, meaningful work, school, or other activity, satisfying relationships, and the freedom to pursue personal goals.

Progress on individual and system outcomes issues include:

- Developed guidelines for research on other state and national outcome systems;
- Developed domains for mh/dd/sa individual outcomes;
- Developed domains for mh/dd/sa system outcomes;
- Developed detail timeline for completion of outcome system design;
- Completed review of Division outcome instruments;
- Developed issues paper for decision points leading to next steps;
- Examined federal block grant outcome reporting requirements;
- Identified elements in Division outcome instruments used to meet federal reporting requirements;

- Studying feasibility of an electronic direct entry data reporting system.

An overall financing strategy is included in the current State Plan. Additionally, a draft report on the cost modeling study for administrative functions of LME's has been received and is under review by the Division. After evaluation of certain assumptions used in the preparation of the project, the funding plan for LME costs can be finalized. Cost modeling for the services piece continues, to be followed by the project on performance-based contracting.

Section 3(a),(5) Format and Content of Business Plans, Method for Evaluation: The State Plan Revision that was released on July 1st contains the finalized format and content for local business plans. There is a weighted scoring document and forms and checklists for completing the plan and preparing for submission to the Department. Notice of rulemaking will be published in the next register.

Section 3(a), (6) Readiness to Implement Reform: Submitted with State Plan 2001 in DHHS Readiness Addendum. This item will be dropped from future reports.

Section 3(a), (7) Consumer Advocacy Program and Advocacy Consolidation Study: This item was covered earlier in this report.

Section 3(a),(8) Consolidation Plan, Letters of Intent: Letters of Intent have been received from 48 counties. The Phase I implementation group represents up to 61 counties depending on the number of successful mergers currently in negotiations. A report on the number of voluntary consolidations will be submitted to the Secretary and the LOC by July 1, 2003. A further progress report will be included in the July 2004 State Plan Revision. If the remaining number of Area/County programs exceeds 20, the Secretary will submit a consolidation plan to the LOC by December 31, 2004. (See page 15, State Strategic Business Plan).

Section 3(a), (9) Submission of Local Business Plans: Counties and their area programs/LME's are actively developing their local business plans. See attached letter from Division Director to LOC Chairs outlining three phase-in periods to the new system. Those LME's in the first phase-in group are already meeting regularly together and with Division leadership to develop their plans. Those regions planning to phase in either the second or third phase-in period will be expected to provide full information about their progress in their local business plan submittal which is due in final form by April 1, 2003.